

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **399**

Primary Registration District No. **1008**

1. PLACE OF DEATH

(a) County **Jackson**  
(b) City or town **Independence**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution **Gen'l. # 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **7 days**  
(Specify whether years, months or days)  
In this community **30 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**  
(c) City or town **Independence**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **H 19 W. Hocker**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME

**LEON BOLD CHINN**

3. (b) If veteran, name war **no**  
3. (c) Social Security No. **496-09-4537**

4. Sex **Male** 5. Color or race **negro** 6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife **none** 6. (c) Age of husband or wife if alive years

7. Birth date of deceased **Apr 14 1910**  
(Month) (Day) (Year)

20. DATE OF DEATH: Month **12** day **29** year **1940**  
hour **10** minute **40** M.

21. I hereby certify that I attended the deceased from **2-9** to **19**, 19**40**.  
that he **actually** died on **12-29-40** at death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary embolism**  
Due to **thrombosis of iliac vein**  
Due to **fracture of right tibia & fibula**  
Other conditions **fracture of ribs**  
(Include pregnancy within 3 months)

PHYSICIAN  
Major findings: Of operations  
Of autopsy **yes**  
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **Accident**  
(b) Date of occurrence **12-29-40**  
(c) Where did injury occur? **Ind. K. Co. Mo**  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, or in public place?

18. (a) Signature of funeral director **Woodlawn**  
(b) Address **2117 Yone St**  
19. (a) **12-31-40** (Date received local registrar)  
(b) **M. M. Brown** (Registrar's signature)

MOTHER FATHER

11. Industry or business  
12. Name **James Chinn** 5  
13. Birthplace **Salisbury**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Coats**  
15. Birthplace **Washington** **no**  
(City, town, or county) (State or foreign country)  
16. (a) Informant's own signature **Stella Chinn**  
(b) Address **H 19 W. Hocker**  
17. (a) **Burial** (Burial, cremation, or removal)  
(b) Date thereof **12-31-40**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Woodlawn**  
**Bellevue Cem. Feagin**  
(Specify type of place)

219 M  
103

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Julius A. H. Teerlin*

Licensed Embalmer No. *2229*

P. O. Address *1217 Ymc St*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

**JAN 8 1941**

# MISSOURI STATE BOARD OF HEALTH STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 5008

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Jackson  
 (b) City or town W. L.  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
 In this community \_\_\_\_\_  
years, months or days

**3. (a) PRINT FULL NAME** Leon B Chinn  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced A  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased \_\_\_\_\_  
(Month) (Day) (Year)  
 8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

**MOTHER** { 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 1/31/40 (b) M. M. Brown  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**20. DATE OF DEATH** Month Dec. 29 - 40  
 year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to Auto transportation

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 210 w

Of operations: hi

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Auto  
 (b) Date of occurrence Dec 27-40  
 (c) Where did injury occur? Indep. Mo  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

Pedestrian struck by car  
(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**SUPPLEMENTARY**

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

S-41615 - 1940